DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 0 2 8

2. STATE: Minnesota

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR sec. 440.20, 440.50, 440.70, 440.80, 440.167 & 42 CFR 447.201(b)

7. FEDERAL BUDGET IMPACT:
a. FFY '01 $ 57,314
b. FFY '02 $ 56,069

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 3.1-A, pp. 12-12a, 19-19d, 36-36b, 38-38d, 44-44e, 78-78r
Att. 3.1-B, pp. 11-11a, 18-18d, 35-35b, 37-37d, 43-43e, 77-77r
Att. 4.19-B, pp. 10-10d & 19

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Att. 3.1-A, pp. 12-12a, 19-19d, 36-36a, 38-38c, 44-44e, 78-78q
Att. 3.1-B, pp. 11-11a, 18-18d, 35-35a, 37-37c, 43-43e, 77-77q
Att. 4.19-B, pp. 10-10d & 19

10. SUBJECT OF AMENDMENT:

Services: Outpatient, Physicians', Medical Supplies, Private Duty, Hearing, Speech-Language and Hearing Therapy & Personal Care; Rates: Anesthesiologist and CRNA

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Ann Berg for

13. TYPED NAME:
Mary B. Kennedy

14. TITLE:
Medicaid Director

15. DATE SUBMITTED:
December 28, 2000

16. RETURN TO:

Stephanie Schwartz
Minnesota Department of Human Services
Federal Relations Unit
444 Lafayette Road No.
St. Paul, Minnesota 55155-3853

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
12/29/00

18. DATE APPROVED: 3/26/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:
Cheryl A. Harris

21. TYPED NAME:
Cheryl A. Harris

22. TITLE:
Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

RECEIVED
DEC 29 2000
DMIO - IL/IN/OH

FORM HCFA-179 (07-92)

Instructions on Back

MINNESOTA

MEDICAL ASSISTANCE

Federal Budget Impact of Proposed State Plan Amendment TN 00-28
Outpatient, Physicians', Medical Supplies, Private Duty, Hearing, Speech-Language-and Hearing Therapy and Personal Care Services; Anesthesiologist and CRNA Rates

1. TN 00-28 deletes language requiring that psychiatric services are provided not more frequently than a set number of days (Attachments 3.1-A/B, item 5.a.). This change is made because the Department no longer requires certain psychiatric services to meet such "spacing requirements."

   The State plan amendment also deletes the language that allows specific psychiatric services to be provided when "additional coverage is prior authorized" in favor of general language that acknowledges that some psychiatric services require prior authorization. Because the prior authorization requirements are subject to change, the Department adds general language so that the State plan need not be amended with each a change. Changes in prior authorization requirements are noted in the *State Register*, so the new language notes that services require prior authorization as specified in the *State Register*.

   There is no budget impact.

2. TN 00-28 amends the language applicable to outpatient day treatment and partial hospital programs (Attachments 3.1-A/B, item 2.a.) for the same reason as noted in the second paragraph of item #1. There is no budget impact.

3. TN 00-28 amends Attachments 3.-1A/B, items 7.c. (medical supplies, equipment and appliances suitable for use in the home) and 11.c. (speech, language and hearing therapy services). Because augmentative and alternative communication (AAC) devices are considered medical equipment, the language governing coverage of AACs is moved from item 11.c. to item 7.c. There is no budget impact.

4. TN 00-28 amends Attachments 3.1-A/B, item 7.c. by deleting the requirement that medical supplies, equipment and appliances cannot be provided to recipients in licensed health care facilities. This is the same change made to recently resubmitted TN 97-12 (governing home care services). State plan amendment TN 97-12 was amended after several discussions with HCFA, as noted in the November 21, 2000 TN 97-12 resubmittal cover letter.

5. TN 00-28 amends Attachments 3.1-A/B, item 8 (private duty nursing services) to delete the language excluding private duty nursing services if the private duty nursing, when combined with home health services, personal care services, and foster care payments, less the base rate, exceed the total amount that public funds would pay for the recipient's care in a medical institution. Language is added to clarify that private duty nursing services are not provided when other, more cost-effective, medically-appropriate services are available.

This is the same change made in recently resubmitted TN 97-12 (governing home health care services). TN 97-12 was amended after several discussions with HCFA, as noted in the November 21, 2000 TN 97-12 resubmittal cover letter.

6. TN 00-28 amends Attachments 3.1-A/B, item 26 (personal care services) to delete the language excluding personal care services if the personal care services, when combined with home health services, private duty nursing services, and foster care payments that exceed the total amount that public funds would pay for the recipient's care in a medical institution. Language is added to clarify that personal care services are not provided when other, more cost-effective, medically-appropriate services are available.

   This is the same change made in recently resubmitted TN 97-12, discussed above.

   The Department expects no budget impact due to this deletion.

7. TN 00-28 updates the current rate methodology language when an anesthesiologist directs qualified medical personnel (Attachment 4.19-B, item 5.a.).

   Minnesota Statutes, §256B.0625, subdivision 3 requires that rates for anesthesia services be paid according to the formula utilized by Medicare program and that the Department use a specific conversion factor (currently $18.00). Current State plan rate language is based on outdated Medicare formulas. New language adopts Medicare's current formulas, and, to ensure that anesthesiologists' rates do not drop significantly due to the updated Medicare formulas, adds a state "enhancement" multiplier of 1.86.

   The new language applies when an anesthesiologist directs one to four certified registered nurse anesthetists (CRNAs), student registered nurse anesthetists, or anesthesia residents. Current language provides for payment when a CRNA is being directed; the new language, following Medicare, also allows for payment for directing student registered nurse anesthetists and anesthesia residents.

   Language governing anesthesiologist direction of five or more CRNAs is not new. What is new is Department policy of paying for supervision of five or more anesthesia residents.

The Department expects the budget savings will be as follows:

	FFY '01	FFY '02
Federal savings	**($147,921)**	**($144,708)**
State savings	($141,495)	($144,708)
TOTAL	($289,416)	($289,416)

8. TN 00-28 updates the current rate methodology language governing administration of anesthesia by CRNAs who are directed by anesthesiologists in outpatient settings (Attachment 4.19-B, item 6.d.D.).

As in item #7, current State plan rate language is based on outdated Medicare formulas. New language adopts the current Medicare formulas. Item (2)(a) restates current language but in a fraction. Item (2)(b) adds a state "enhancement" multiplier of 1.264 and states the methodology in a fraction. The enhancement is added for the same reason as in item #7–to ensure that providers' rates do not dip significantly due to the updated Medicare formula.

The Department anticipates budget costs because, for every additional claim for directing one CRNA, there will be an additional claim for CRNA services provided under the direction of an anesthesiologist. The Department expects the budget impact will be as follows:

	FFY '01	FFY '02
Federal impact	**$90,607**	**$88,639**
State impact	$86,671	$88,639
TOTAL	$177,278	$177,278

5.a. Physicians' services (continued):

Services	Limitations
Family psychotherapy without patient present	~~Not more frequently than once every 5 calendar days,~~ Up to 20 hours per calendar year when combined with family psychotherapy~~, unless additional coverage is prior authorized~~.*
Family psychotherapy	~~Not more frequently than once every 5 calendar days,~~ Up to 20 hours per calendar year when combined with family psychotherapy without patient present~~, unless additional coverage is prior authorized~~.*
Family psychotherapy discretionary	Up to 6 hours per calendar year.
Multiple family group psychotherapy	Up to 10 times per calendar year, not to exceed 2 hours per occurrence.*
Group psychotherapy	Up to 78 hours per year, not to exceed 3 hours within a 5 calendar day period.*
Chemotherapy management including prescription, use, and review of medication with not more than minimal medical psychotherapy - provided the medication required is antipsychotic or antidepressant provided by a physician, clinical nurse specialist with a specialty in psychiatric nursing or mental health, or registered nurse who is also a mental health professional or practitioner and is employed or under contract with the physician or provider who is providing clinical supervision.	52 clinical units per calendar year, not more than 1 unit per week.

5.a. Physicians' services (continued):

- **Sterilization procedures**: Physicians must comply with regulations concerning informed consent for voluntary sterilization procedures.

- **Laboratory services:** These services must be ordered by a physician. Only laboratory services provided by Medicare certified laboratories are eligible for MA payment. Payment to physicians is done in accordance with 42 CFR §447.10(g).

- **Abortion services**: These services are covered when the abortion is medically necessary to prevent death of a pregnant woman, and in cases where the pregnancy is the result of rape or incest. Cases of rape and incest must be reported to legal authorities unless the treating physician documents that the woman was physically or psychologically unable to report.

- **Telemedicine consultation services (until July 1, 2001):** These services must be made via two-way, interactive video or store-and-forward technology. The patient record must include a written opinion from the consulting physician providing the telemedicine consultation. Coverage is limited to three consultations per recipient per calendar week.

- **Prior Certification**: Physicians must request and obtain certification prior to admitting medical assistance recipients for inpatient hospital services, except for emergencies, delivery of a newborn, inpatient dental procedures, or inpatient hospital services for which a recipient has been approved under Medicare.

- **Delivery of services**: Physician services must be provided by or under the supervision of a medical doctor or doctor of osteopathy licensed under Minnesota Statutes, §147 and within the scope of practice defined by law. Supervised physician services are provided by enrolled physician assistants and physician extenders.

- **Second medical opinion:** Second medical opinion is a condition of reimbursement for **tonsillectomy and/or adenoidectomy, hysterectomy and cholecystostomy**.

5.a. Physicians' services (continued):

- **Organ transplants**: These services are covered in accordance with the standards and statutory authority provided in Attachment 3.1-E.

- **Physical therapy, occupational therapy, ~~audiology~~ and speech, language, ~~pathology~~ and hearing therapy services**: Coverage of these services is limited to services within the limitations provided under items 11.a. to 11.c., Physical therapy and related services.

- **Anesthesia services:** Anesthesiologists may personally perform or may medically direct (supervise) the services.

- **Physician services to pregnant women**: Physicians providing these services must be certified by the Department, through a provider agreement, as qualified to provide services to pregnant women.

- **Physician services to children under 21 years of age**: Physicians providing these services must be certified by the Department, through a provider agreement, as qualified to provide services to children under 21 years of age.

- **Pediatric vaccines**: Physicians who administer certain pediatric vaccines (i.e., vaccines that are part of the Minnesota Vaccines for Children Program) within the scope of their licensure must enroll in the Minnesota Vaccines for Children Program. The Minnesota Vaccines for Children Program is established pursuant to §1928 of the Act.

7.c. Medical supplies, equipment and appliances suitable for use in the home.

- Covered medical supplies, equipment and appliances suitable for use in the home are those ~~which~~ that are: (a) medically necessary; (b) offered by a physician; (c) documented in a plan of care that is reviewed and revised as medically necessary by the physician at least once a year; and (d) provided to the recipient at the recipient's own place of residence that is a place other than a hospital, nursing facility, or intermediate care facility for the mentally retarded (ICF/MR)~~, or licensed health care facility~~.

- Medical supplies and equipment ordered in writing by a physician are paid with the following limitations:

  1) A purchase of nondurable medical supplies not requiring prior authorization must not exceed an amount necessary to provide a one-month supply.

  2) Maintenance or service made at routine intervals based on hours of use or calendar days to ensure that equipment in proper working order is ~~reimbursable~~ payable.

  3) The cost of a repair to durable medical equipment that is rented or purchased by the Medical Assistance program under a warranty is not eligible for medical assistance payment if the repair is covered by the warranty.

  4) In the case of rental equipment, the sume of rental payments during the projected period of the recipient's use must not exceed the purchase price allowed by medical assistance unless the sum of the projected rental payments in excess of the purchase price receives prior authorization. All rental payments must apply to purchase of the equipment.

- **Augmentative and alternative communication devices** are defined as devices dedicated to transmitting or producing messages or symbols in a manner that compensates for the impairment and disability of a recipient with severe expressive communication disorders. Examples include: communication picture books, communication charts and boards, and mechanical or electronic dedicated devices.

7.c. Medical supplies, equipment and appliances suitable for use in the home. (continued)

3) Durable medical equipment that will serve the same purpose as equipment already in use by the recipient.

4) Medical supplies or equipment requiring prior authorization when prior authorization is not obtained before billing.

5) Dental hygience supplies and equipment.

6) Stock orthopedic shoes.

- Medical suppliers who do not participate or accept Medicare assignment must refer and document the referral of dual eligibles to Medicare providers when Medicare is the appropriate payer.

8. Private duty nursing services.

- Private duty nursing services are only covered when medically necessary, ordered in writing by the physician, and documented in a written plan of care that is reviewed and revised as medically necessary by the physician at least once every 62 days.

- ~~Except for the services identified in an Individualized Education Plan under item 13.d., private~~ Private duty nursing services are not reimbursable if an enrolled home health agency is available and can adequately provide the specified level of care, or if a personal care assistant can be utilized.

- Private duty nursing services includes extended hour nursing services provided by licensed registered nurses or licensed practical nurses employed by a Medicare-certified home health agency or self-employed.

- Department prior authorization is required for all private duty nursing services. Prior authorization is based on medical necessity; physician's orders; the recipient's needs, diagnosis, and condition; an assessment of the recipient; the plan of care; and cost-effectiveness when compared to alternative care options. For recipients who meet hospital admission criteria, the Department shall not authorize more than 16 hours per day of private duty nursing service or up to 24 hours per day of private duty nursing service while a determination of eligibility is made for recipients who are applying for services under Minnesota's approved model home and community-based services waiver or during an appeal to the appropriate regulatory agency to determine if a health benefit plan is required to pay for medically necessary nursing services. For recipients who do not meet hospital admission criteria, the Department may authorize up to 9.75 hours per day of private duty nursing service.

- Authorized units of private duty nursing service may be used in the recipient's home or outside of the recipient's home if normal life activities take the recipient outside of their home and without private duty nursing service their health and safety would be jeopardized. To receive private duty nursing services at school, the recipient or his or her responsible

8. Private duty nursing services. (continued)

party must provide written authorization in the recipient's care plan identifying the chosen provider and the daily amount of services to be used at school.

- Private duty nursing providers that are not Medicare certified must refer and document the referral of dual eligibles to Medicare providers when Medicare is the appropriate payer.

- Recipients may receive shared private duty nursing services, defined as nursing services provided by a private duty nurse to two recipients at the same time and in the same setting. Decisions on the selection of recipients to share private duty nursing services must be based on the ages of the recipients, compatibility, and coordination of their care needs. For purposes of this item, "setting" means the home or foster care home of one of the recipients, a child care program that is licensed by the state or is operated by a local school district or private school, or an adult day care that is licensed by the state.

  The provider must offer the recipient or responsible party the option of shared care. If accepted, the recipient or responsible party may withdraw participation at any time.

  The private duty nursing agency must document the following in the health service record for each recipient sharing care:

  a) authorization by the recipient or responsible party for the maximum number of shared care hours per week chosen by the recipient;

  b) authorization by the recipient or responsible party for shared service provided outside the recipient's home;

  c) authorization by the recipient or responsible party for others to receive shared care in the recipient's home;

8. Private duty nursing services. (continued)

d) revocation by the recipient or responsible party of the shared care authorization, or the shared care to be provided to others in the recipient's home, or the shared care to be provided outside the recipient's home; and

e) daily documentation of the shared care provided by each private duty nurse including:

1) the names of each recipient receiving shared care together;

2) the setting for the shared care, including the starting and ending times that the recipients received shared care; and

3) notes by the private duty nurse regarding changes in the recipient's condition, problems that may arise from the sharing of care, and scheduling and care issues.

In order to receive shared care:

a) the recipient or responsible party and the recipient's physician, in conjunction with the home health care agency, must determine:

1) whether shared care is an appropriate option based on the individual needs and preferences of the recipient; and

2) the amount of shared care authorized as part of the overall authorization of private duty nursing services;

b) the recipient or responsible party, in conjunction with the private duty nursing agency, must approve the setting, grouping, and arrangement of shared care based on the individual needs and preferences of the recipients;

c) the recipient or responsible party, and the private duty nurse, must consider and document in the recipient's health service record:

8. Private duty nursing services. (continued)

1) the additional training needed by the private duty nurse to provide care to two recipients in the same setting and to ensure that the needs of the recipients are appropriately and safely met;

2) the setting in which the shared private duty nursing care will be provided;

3) the ongoing monitoring and evaluation of the effectiveness and appropriateness of the service and process used to make changes in service or setting;

4) a contingency plan that accounts for absence of the recipient in a shared care setting due to illness or other circumstances. The private duty nurse will not be paid if the recipient is absent;

5) staffing backup contingencies in the event of employee illness or absence;

6) arrangements for additional assistance to respond to urgent or emergency care needs of recipients.

- The following services are not covered under medical assistance as private duty nursing services:

a) private duty nursing services provided by a licensed registered nurse or licensed practical nurse who is the recipient's spouse, legal guardian, or parent of a minor child or foster care provider of a recipient who is under age 18;

b) private duty nursing services that are the responsibility of the foster care provider;

c) private duty nursing services when the number of foster care residents is greater than four;

8. Private duty nursing services. (continued)

d) private duty nursing services when ~~combined with home health services, personal care services, and foster care payments, less the base rate, that exceed the total amount that public funds would pay for the recipient's care in a medical institution (This is a utilization control limitation conducted on a case-by-case basis in order to provide the recipient with the most~~ other, more cost-effective, medically appropriate services are available~~.)~~; ~~or~~ and

e) private duty nursing services provided to a resident of a hospital, nursing facility, intermediate care facility, or a licensed health care facility.

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

Coverage of **hearing (audiology) therapy services** does *not* include:

(1) Services that are not documented in the recipient's clinical record, even if the services were authorized by a physician.
(2) Training or consultation provided by an audiologist to an agency, facility, or other institution.
(3) Services provided by an audiologist other than the audiologist billing for the services, or a person completing the clinical fellowship year under the supervision of the audiologist, unless the audiologist provided the services in a hospital, rehabilitation agency, home health agency, or clinic, or as an employee of a physician or long-term care facility; in which case the contracting or employing facility, agency, or person must bill for the services.

Hearing aid services: After a physician rules out medical and surgical contraindications, the physician refers the recipient for an audiologic evaluation. An audiologist or otolaryngologist provides audiologic testing, and if a hearing aid is indicated, prescribes a specific hearing aid offered under the hearing aid volume purchase contract or refers the recipient to a hearing aid services provider.

Payment is made to hearing aid services providers for hearing aids, dispensing fees, hearing aid repairs, accessories, ear molds when not provided with the hearing aid and batteries.

Coverage of **hearing aids** is limited to:

(1) One monaural or one set of binaural hearing aids within a period of five years unless prior authorized. A hearing aid will not be replaced when the recipient has received a replacement hearing aid twice within the five year period previous to the date of the request.
(2) Non-contract hearing aids require prior authorization.

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

Coverage of **hearing aids** does *not* include:

(1) Replacement batteries provided on a scheduled basis regardless of their actual need.
(2) Services specified as part of the contract price when billed on a separate claim for payment. This includes any charges for repair of hearing aids under warranty.
(3) Routine screening of individuals or groups for identification of hearing problems.
(4) Separate reimbursement for postage, handling, taxes, mileage, or pick-up and delivery.
(5) Nonelectronic hearing aids, telephone amplifiers, vibrating molds, dry aid kits, and battery chargers.
(6) Maintenance, cleaning, and checking of hearing aids, unless there has been a request or referral for the service by the person who owns the hearing aid, the person's family, guardian or attending physician.
(7) Loaner hearing aid charges.
(8) Canal type hearing aids.
(9) A noncontract hearing aid that is obtained without prior authorization.
(10) Services included in the dispensing fee when billed on a separate claim for payment.
(11) Hearing aid services to a resident of a long-term care facility if the services did not result from a request by the resident, a referral by a registered nurse or licensed practical nurse who is employed by the long-term care facility, or a referral by the resident's family, guardian or attending physician.
(12) Hearing aid services prescribed or ordered by a physician if the physician or entity commits a felony listed in United States Code, title 42, section 1320a-7b, subject to the "safe harbor" exceptions listed in 42 CFR 1001.952.
(13) Replacement of a lost, stolen or damaged hearing aid if MA has provided three hearing aids in the five years prior to the date of the request for a replacement.